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Citation for published version:

McKinstry, B & Dacre, J 2008, 'Are there too many female medical graduates?', *British Medical Journal (BMJ)*, vol. 336, no. 7647, pp. 748-749. <https://doi.org/10.1136/bmj.39505.491065.94>

Digital Object Identifier (DOI):

[10.1136/bmj.39505.491065.94](https://doi.org/10.1136/bmj.39505.491065.94)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Publisher's PDF, also known as Version of record

Published In:

British Medical Journal (BMJ)

Publisher Rights Statement:

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Are there too many female medical graduates?

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YES Too many female graduates are bad for medicine, just as too many male ones have been in the past. The numbers of men and women entering medical school should roughly reflect the numbers in society. The case for this is simply on grounds of equal opportunity. But there are also strong economic and workforce planning reasons. I will argue this largely from the perspective of my own specialty, general practice, which illustrates most strongly the impact of the feminisation of medicine.

Over the past 30 years the proportion of women attending medical schools has steadily risen in many countries including the UK, US, Canada, and Australia.^{1,2} In 2002-3, all UK medical schools had more female students than male, with the percentage of women exceeding 65% in some.³ This partly reflects the increasing number of women applying for medical courses and their increasing examination success in science. For many years the relative lack of female doctors was bemoaned, but the tables are turning and soon male doctors will be in a minority. This is already the case in primary care in many parts of the UK.

Workforce implications

Why does this matter? The main concerns centre on the work patterns of women doctors and also around the development of the profession. Women doctors concentrate in a few specialties regarded as family friendly (for example, primary care⁴ and psychiatry⁵) and tend not to take up some specialties such as surgery.⁴ This unequal distribution means that some specialties feel the implications of part time working and maternity leave, such as lack of continuity of care and resource use disproportionately.

Female doctors are more likely to work part time than their male colleagues.⁶ Despite many years of feminist discourse society still expects women rather than men to reduce work commitments to look after children and not to return to full time work until the chil-

dren are older. However, research among general practitioners has shown that many women in their 50s, when their children are relatively independent, continue to work part time, often because of other caring demands.^{7,8} In addition, more female general practitioners plan to retire before the age of 60 than men, shortening their working life further.⁷ In psychiatry, one study found that nearly twice as many female consultants (41%) as male planned to finish work on or before their 55th birthday.⁹ Fewer women than men choose to work out of hours,⁸ and the increase in women doctors may have partly influenced

the recent abdication of out of hours work by general practitioners in the UK. Although some research suggests that younger male doctors are also seeking part time careers,¹⁰ there is little evidence that they are actually opting for this lifestyle.

Time bomb

We are yet to feel the full effect of the feminisation of primary care in the UK and elsewhere. Above the age of 45 years men, mostly working full time, are still the majority, whereas most general practitioners younger than 45 years are female and mainly working part time.¹¹ As older mainly full time doctors retire, unless employment behaviour changes from past patterns, there will be a major shortfall in primary care provision.

This demographic change may also affect education, research, and development. In an American study of women in internal medicine,¹² the researchers found that compared with men with children, women with children had fewer publications (18.3 v 29.3; $P < 0.001$). However, no significant differences between the sexes were seen for doctors without children. In our study in primary care we found that women were contributing about 60% of the activity of men in development aspects of general practice such as training, teaching, research, and committee work.⁷ It is not clear to what extent this is through choice or lack of opportunity.

Some have argued that the future feminisation of medicine is justified on the grounds that women perform better than men in undergraduate and postgraduate examinations.



Is the increasing feminisation of health care a cause for celebration or a threat to future delivery of services?

Although several large studies have shown differences, these differences are very small and of little practical importance.¹³ Men and women may bring different, complementary skills to medicine. There is some evidence that women engage in more patient centred communication.¹⁴ However, women consult for longer with patients,¹⁴ and in one UK study of out of hours consultations they were 30% more likely to refer to hospital increasing pressure on hospital services.¹⁵ Moreover, recent UK research shows that even full time female consultants see fewer patients than their male colleagues.¹⁶ Empathy and communication skills are important, but so are efficiency and the ability to live with risk.

For years women have been unfairly discriminated against in medicine. I fully support their role and the strengths they bring to modern medicine. However, in the absence of a profound change in our society in terms of responsibility for child care, we need to take a balanced approach to recruitment in the interests of both equity and future delivery of services.

I thank Iain Colthart for his help with the literature review. BMCK is funded by the Chief Scientist Office of the Scottish Government.

Competing interests: None declared.

UK universities are now producing more female doctors than male. **Brian McKinstry** argues we are risking future staffing problems, but **Jane Dacre** thinks there is still some way to go before we reach true equality



REX FEATURES

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NO Medicine needs and wants to attract the best and brightest people, whatever their sex. Some patients prefer to see the same sex doctor as themselves¹—so we should ideally have equal numbers of men and women.

As the first female dean of Duke University School of Medicine said incredulously, after her appointment had made the headlines on national public radio, “Brilliance and ability are not restricted to certain groups, so it seems logical that if they draw from the widest possible talent pool, the very best institutions will naturally have diversity at all levels.”³

Medicine is a caring profession. The attributes of the doctor as documented in the UK General Medical Council’s *Good Medical Practice* include care, consideration, dignity, and respect.⁴ The Royal College of Physicians working party on medical professionalism has agreed that doctors should be committed to integrity, compassion, altruism, continuous improvement, excellence, and working in partnership.⁵ Although these are characteristics

shared by men and women, female doctors in particular engage patients as active partners in care, offer emotional support, and engage in psychological discussion.⁶ Such patient centred care results in better health outcomes.⁷

Under-representation

Women now outnumber men in most medical schools by about 3:2,⁸ but as many of them may want to work flexibly for some of their working life, numbers in the workforce overall are likely to even out.

Despite this increase in female students, there are still few women in some areas, especially clinical academia. The Medical Schools Council report, published in June 2007, showed only 11% of the professorial staff in UK medical schools are women compared with 36% of clinical lecturers. The proportion of women decreases with increasing academic grade. A similar situation exists in the United States, where only 15% of full professors and 11% of department chairs are women.⁹ This is despite several recent studies of leadership that show women are good at empowering others and are good team leaders.¹⁰

Women are also not represented equally across the profession, with specialties requiring more acute and on-call responsibilities and more technical skills seeming less attractive.¹¹ Women’s performance in examinations in our medical schools¹² and in the MRCP examination¹³ is now better than that of men, so the reason for this lack of career progression is not explained by lack of academic aptitude. This is a strong argument for ensuring equality of opportunity in medicine, rather than worrying about having too many women.

Recently, a much larger number of women have taken leading roles in the medical royal colleges and other areas of health care. It may just be a matter of time before the overall numbers at the top of the profession reflect the current increase in numbers of women in the medical schools. Although women may take time off to have children, they retire later so stay in the active workforce for longer¹⁴ and therefore have more time to climb the career ladder and to develop their leadership roles. They also gain broad experience of life outside the workplace.

Both men and women make first rate doctors. They should be encouraged into the profession, but in order to welcome women to the more senior positions, it is worth paying attention to the institutional barriers that prevent their progression into leadership positions. These include lack of role models, lack of flexibility of rotas, and low acceptance of career breaks and part time working. Recent work on leadership styles commends a more collaborative approach, with the development of good team working and communication skills.

Embrace flexibility

The shape of the workforce is changing. Projections suggest that there will be too many doctors looking for jobs in the UK in the near future, and unemployment is already a concern for trainees caught up in the recent debacle with the Medical Training Application Service. The health service will soon have to achieve a 48 hour working week to comply with the European Working Time Directive. Rather than focus on the detrimental effect of having too many female graduates, the feminisation of medicine should be welcomed as an opportunity to be creative with workforce planning and to recognise that a more flexible approach is required to deliver good quality patient care at all times of the day and night. This change to a more flexible way of working

Women and men wanting a more flexible career path into medicine should be welcomed

will be more acceptable to colleagues with domestic and other commitments and is likely to result in more women taking on leadership positions.

Women and men wanting a more flexible career path into medicine should be welcomed. To encourage them to take on the leadership roles that the profession needs, however, some changes need to be considered, including greater availability of flexible on-site child care and easily accessible and funded part time training options. A few small steps would support giant leaps in the development, quality, and leadership of the medical workforce.

Competing interests: JD chairs the Royal College of Physicians research project on women in medicine.

All references are in the version on bmj.com

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